

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017036

STATE FILE NUMBER

Registrar's No. 95

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| FILED JUN 3 1959 | | Registration District No. 29 | | Primary Registration District No. | |
| 1. PLACE OF DEATH a. COUNTY CASS | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY CASS | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Regular Township | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | c. CITY OR TOWN HARRISONVILLE | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Amick of Harrisonville | | Length of stay in lb Now | | d. STREET ADDRESS (If outside, give location) 704 GREEN ST | |
| 3. NAME OF DECEASED (Type or print) First JAMES Middle WASHINGTON Last BUTCHER | | | 4. DATE OF DEATH Month MAY Day 26 Year 1959 | | |
| 5. SEX MALE | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept 23, 1873 | 9. AGE (In years) Months 85 Days 8 | IF UNDER 1 YEAR Hours 3 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Active Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) SAVANNAH, Missouri | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13a. FATHER'S NAME James W. Butcher | | 13b. MOTHER'S MAIDEN NAME Ann R. Townsend | |
| 14. NAME OF HUSBAND OR WIFE Lucille W. Butcher | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Marion Butcher | | Address HARRISONVILLE, MO | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral contusion & basilar skull fracture Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) No | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Auto accident 4 miles N Harrisonville | |
| 20c. TIME OF INJURY Hour 7 a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> Month 5 Day 26 Year 59 | | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) On Hi-way # 21 | |
| 20f. CITY, TOWN, OR LOCATION Harrisonville | | COUNTY Cass | | STATE MO | |
| 21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 7 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE J. Taylor | | (Degree or title) 3 | | 22b. ADDRESS 222 Pleasant Hill | |
| 22c. DATE SIGNED 5/26/59 | | 23a. BURIAL CREMATION, BENEFIT (Specify) BURIAL | | 23b. DATE MAY 28 1959 | |
| 23c. NAME OF CEMETERY OR CREMATORY ORIENT Cemetery | | 23d. LOCATION (City, town, or county) HARRISONVILLE, Missouri | | (State) | |
| 24. FUNERAL DIRECTOR Anderson Dickey Harrisonville, Mo | | ADDRESS 5-31-59 | | 25. DATE RECD. BY LOCAL REG. | |
| 26. REGISTRAR'S SIGNATURE Mrs. Ray Deane | | | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Robert W. Lockman*

Licensed Embalmer No. *4902*
P. O. Address *Hammond, Ind.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.